



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS ORTHOPEDIC HOSPITAL
C/O HOLLOWAY & GUMBERT
3701 KIRBY DRIVE STE 1288
HOUSTON TX 77098-3926

Carrier's Austin Representative Box
#28

MFDR Date Received

JULY 13, 2006

Respondent Name

LIBERTY MUTUAL FIRE INSURANCE CO

MFDR Tracking Number

M4-06-7044-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated July 12, 2006: "...Texas Orthopedic Hospital billed its usual and customary charges for its services. The total sum billed was \$88,288.08...Per Rule 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of \$40K, the entire admission will be paid using the stop-loss reimbursement factor ('SLRF') of 75%...the fees paid by Liberty Mutual Insurance Company do not conform to the reimbursement section of rule 134.401...it is the position of Texas Orthopedic Hospital that all charges relating to the admission of [Claimant] are due and payable as provided for under Texas law and the Rules of the Division, as currently adopted and published at 28 TAC §134.400 *et seq.*"

Requestor's Supplemental Position Summary Dated August 2, 2006: "Pursuant to TDI Rule 133.307(g)(3), please find enclosed the Affidavit of Vanessa East that is relevant to the medical care and treatment provided to [Claimant] at Texas Orthopedic Hospital, which was inadvertently omitted from the documentation submitted in our original request for MDR packet dated July 12, 2006."

Amount in Dispute: \$35,963.83

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated August 1, 2006: "The bill was paid per the Texas Fee Schedule – Acute Care Inpatient Fee Guidelines...The inpatient stay should only be paid as stop loss if BC>\$40,000.00 and the stay represents 'unusually extensive services' The bill was reviewed. There does not appear to be any unusual extensive services provided during this admission, therefore; the provider was not paid at the TX FS Stop Loss Reimbursement threshold of 75%. The provider was paid at the TX FS per diem plus carve outs, less the PPO discount (10% off TX FS allowable amount.)...Liberty Mutual does not believe that Twelve Oaks Medical Center is due any further reimbursement for services rendered to [Claimant] between dates of service 7/15/2005-7/23/2005."

Response Submitted by: Liberty Mutual Insurance Company

Respondent's Supplemental Position Summary Dated August 18, 2006: "The additional information has been reviewed and our position remains the same."

Response Submitted by: Liberty Mutual Insurance Company

Respondent's Supplemental Position Summary Dated November 30, 2011: "In this dispute...[t]he requestor offers no explanation, or discussion on how the services provided may be considered unusually

extensive'...Requestor's position statement refers the Division to no specific aspect of the admission which might demonstrate the services were either unusually costly or unusually extensive and it makes only passing mention of either the operation performed on any of the medical records...As with the unusually extensive prong, the Hospital bears the burden of proof to demonstrate that the services it provided are unusually costly...The Requestor in this matter offers neither explanation nor discussion as to how the services it provided may be considered unusually costly. It simply presents an inflated bill and demands payment...Because Requestor has not met its burden of demonstrating unusually extensive services, and the documentation adduced thus far fails to provide any rationale for the Requestor's qualification for payment under the Stop-Loss Exception, Respondent appropriately issued payment per the standard Texas Surgical per diem rate. No additional monies are due to the Requestor."

Responses Submitted by: Hanna & Plaut LLP

SUMMARY OF FINDINGS

| Disputed Dates | Disputed Services | Amount In Dispute | Amount Due |
|---|-----------------------------|-------------------|------------|
| July 15, 2005 through July 23, 2005 | Inpatient Hospital Services | \$35,963.83 | \$0.00 |

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
 - Effective July 13, 2008, the Division's rule at former 28 Texas Administrative Code § 134.401 was repealed. The repeal adoption preamble specified, in pertinent part: "Section 134.401 will continue to apply to reimbursements related to admissions prior to March 1, 2008." 33 *Texas Register* 5319, 5220 (July 4, 2008).
 - Former 28 Texas Administrative Code § 134.401(a)(1) specified, in pertinent part: "This guidelines shall become effective August 1, 1997. The Acute Care Inpatient Hospital Fee Guideline (ACIHFG) is applicable for all reasonable and medically necessary medical and/or surgical inpatient services rendered after the Effective Date of this rule in an acute care hospital to injured workers under the Texas Workers' Compensation Act." 22 *Texas Register* 6264, 6306 (July 4, 1997).
- 28 Texas Administrative Code §134.1, 27 *Texas Register* 4047, effective May 16, 2002, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- M – Z585 – THE CHARGES FOR THIS PROCEDURE EXCEEDS FAIR AND REASONABLE. (Z585)
- F – Z695 – THE CHARGES FOR THIS HOSPITALIZATION HAVE BEEN REDUCED BASED ON THE FEE SCHEDULE ALLOWANCE. (Z695)
- C – P303 – THIS SERVICE WAS REVIEWED IN ACCORDANCE WITH YOUR CONTRACT. (P303)
- C – PA – FIRST HEALTH NETWORK
- F – Z560 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE OR USUAL AND CUSTOMARY ALLOWANCE. (Z560)
- Z612 – THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR CONTRACT WITH FIRST HEALTH NETWORK. FOR QUESTIONS REGARDING THIS ANALYSIS, PLEASE CALL (800) 937-6824. (Z612)
- Z782 – PAYMENT REDUCED DUE TO LACK OF WHOLESALE INVOICE. (Z782)
- Z289 – THE AMOUNT PAID PREVIOUSLY WAS LESS THAN IS DUE. THE CURRENT RECOMMENDED AMOUNT IS THE RESULT OF SUPPLEMENTAL PAYMENT. (Z989)

- X598 – CLAIM HAS BEEN RE-EVALUATED BASED ON ADDITIONAL DOCUMENTATION SUBMITTED; NO ADDITIONAL PAYMENT DUE. (X598)
- Z951 – WE ARE UNABLE TO RECOMMEND AN ADDITIONAL ALLOWANCE SINCE THIS CLAIM WAS PAID IN ACCORDANCE WITH THE STATE'S FEE SCHEDULE GUIDELINES, FIRST HEALTH BILL REVIEW'S USUAL AND CUSTOMARY POLICIES, AND/OR WAS REVIEWED IN ACCORDANCE WITH THE PROVIDER'S CONTRACT WITH FIRST HEALTH. (Z951)
- 18 – U301 – THIS ITEM WAS PREVIOUSLY SUBMITTED AND REVIEWED WITH NOTIFICATION OF DECISION ISSUED TO PAYOR/PROVIDER. (DUPLICATE INVOICE. (U301)

Issues

1. Did the audited charges exceed \$40,000.00?
2. Did the admission in dispute involve unusually extensive services?
3. Did the admission in dispute involve unusually costly services?
4. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 South Western Reporter Third 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The division received supplemental information as noted in the position summaries above. The supplemental information was shared among the parties as appropriate. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges **in this case** exceed \$40,000; whether the admission and disputed services **in this case** are unusually extensive; and whether the admission and disputed services **in this case** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection..." 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed \$40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "Audited charges are those charges which remain after a bill review by the insurance carrier has been performed." Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal \$88,288.08. The division concludes that the total audited charges exceed \$40,000.
2. The requestor in its position statement presumes that it is entitled to the stop loss method of payment because the audited charges exceed \$40,000. As noted above, the Third Court of Appeals in its November 13, 2008 opinion rendered judgment to the contrary. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved...unusually extensive services." The requestor failed to demonstrate that the particulars of the admission in dispute constitute unusually extensive services; therefore, the division finds that the requestor did not meet 28 Texas Administrative Code §134.401(c)(6).
3. In regards to whether the services were unusually costly, the requestor presumes that because the bill exceeds \$40,000, the stop loss method of payment should apply. The Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must **demonstrate** that an admission involved unusually costly services thereby affirming 28 Texas Administrative Code §134.401(c)(6) which states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly

services rendered during treatment to an injured worker.” The requestor failed to demonstrate that the particulars of the admission in dispute constitutes unusually costly services; therefore, the division finds that the requestor failed to meet 28 Texas Administrative Code §134.401(c)(6).

4. 28 Texas Administrative Code §134.401(b)(2)(A) titled General Information states, in pertinent part, that “The basic reimbursement for acute care hospital inpatient services rendered shall be the lesser of:
- (i) a rate for workers’ compensation cases pre-negotiated between the carrier and the hospital;
 - (ii) the hospital’s usual and customary charges; and
 - (iii) reimbursement as set out in section (c) of this section for that admission

In regards to a pre-negotiated rate, the services in dispute were reduced in part with the explanation “THIS SERVICE WAS REVIEWED IN ACCORDANCE WITH YOUR CONTRACT.” No documentation was provided to support that a reimbursement rate was negotiated between the workers’ compensation insurance carrier Liberty Mutual Insurance Co. and Texas Orthopedic Hospital prior to the services being rendered; therefore 28 Texas Administrative Code §134.401(b)(2)(A)(i) does not apply.

In regards to the hospital’s usual and customary charges in this case, review of the medical bill finds that the health care provider’s usual and customary charges equal \$88,288.08.

In regards to reimbursement set out in (c), the division determined that the requestor failed to support that the services in dispute are eligible for the stop-loss method of reimbursement; therefore 28 Texas Administrative Code §134.401(c)(1), titled Standard Per Diem Amount, and §134.401(c)(4), titled Additional Reimbursements, apply. The division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

- Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of \$1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that “The applicable Workers’ Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission.” The length of stay was five days. The surgical per diem rate of \$1,118.00 multiplied by the length of stay of five days results in an allowable amount of \$5,590.00.
- 28 Texas Administrative Code §134.401(c)(4)(A), states “When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274).” Review of the requestor’s medical bill finds that the following items were billed under revenue code 278 and are therefore eligible for separate payment under §134.401(c)(4)(A):

| Code | Itemized Statement Description | Serial No. Per Implant Record | UNITS | Cost per Unit | Cost + 10% |
|------|--------------------------------|-------------------------------|-----------------|-----------------------------|------------|
| 0278 | ZIMMER IMPLANT LEFT KNEE | 5880-60-20 | 1 | No support for cost/invoice | \$0.00 |
| 0278 | ZIMMER LEFT KNEE IMPLANT | 5972-65-32 | 1 | No support for cost/invoice | \$0.00 |
| 0278 | ZIMMER IMPLANT | 5880-16-01 | 1 | No support for cost/invoice | \$0.00 |
| 0278 | ZIMMER IMPLANT LEFT KNEE | 5988-16-14 | 1 | No support for cost/invoice | \$0.00 |
| 0278 | ZIMMER IMPLANT LEFT KNEE | 5988-16-19 | 2 | No support for cost/invoice | \$0.00 |
| 0278 | CEMENT PALACOS | 424800 | 4 | \$101.00 | \$444.40 |
| | | | TOTAL ALLOWABLE | | |
| | | | \$444.40 | | |

- 28 Texas Administrative Code §134.401(c)(4)(C) states “Pharmaceuticals administered during the admission and greater than \$250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time.” A review of the submitted itemized statement finds that the requestor billed \$347.97/unit for Hydromorphone 20MG/100. The requestor did not submit documentation to support what the cost to the hospital was for these items

billed under revenue code 250. For that reason, additional reimbursement for these items cannot be recommended.

The total reimbursement set out in the applicable portions of (c) results in \$8,944.00 + \$444.40, for a total of \$9,388.40.

Reimbursement for the services in dispute is therefore determined by the lesser of:

| §134.401(b)(2)(A) | Finding |
|-------------------|----------------|
| (i) | Not Applicable |
| (ii) | \$88,288.08 |
| (iii) | \$9,388.40 |

The division concludes that application of the standard per diem amount and the additional reimbursements under §134.401(c)(4) represents the lesser of the three considerations. The respondent issued payment in the amount of \$23,630.62. Based upon the documentation submitted, no additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the division concludes that the services in dispute are not eligible for the stop-loss method of reimbursement, that a pre-negotiated rate does not apply, and that application of 28 Texas Administrative Code §134.401(c)(1), titled *Standard Per Diem Amount*, and §134.401(c)(4), titled *Additional Reimbursements*, results in the total allowable reimbursement. Based upon the documentation submitted, the requestor's Table of Disputed Services, and reimbursement made by the respondent, the amount ordered is \$0.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

| | | |
|--------------------|---|--------------------|
| _____ Signature | _____ Medical Fee Dispute Resolution Officer | 04/23/2013 Date |
|--------------------|---|--------------------|

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.